# HEALTH INEQUALITIES ASSESSMENT REPORT

**NIHR CLAHRC NWC Health Inequalities Assessment Toolkit (HIAT) version 3**

All outline and full proposals that want support from NIHR CLAHRC NWC need to include a health inequalities assessment report. The steering board will use this report to decide whether a proposal 'fits' with our objective: to make sure that everything we do has the potential to reduce health inequalities and their causes.

In the form below, we ask you to briefly outline your response to each section of the HIAT toolkit. In particular, we would like you to specify any change you have made to your planned activity as a result of your assessment, or explain why you feel changes are not necessary.

You should use the toolkit with the members of the public involved in your activity. Please briefly outline how you have involved them or explain why you did not involve them at this stage.

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| **1. Name of your project** | COMMUNITY CONNECTORS |
| **2. Theme of your project** | KNOWLEDGE EXCHANGE & IMPLEMENTATION |

**3. Who was involved in the assessment (include relevant members of the public)? If you did not involve the public, please say why not.**

Gina Harvey – CLAHRC intern and coordinator of Community Connectors project.

Ian Willman - Service Manager: Localities South

Conal Devitt – Community Connector for Bootle area

2 Community Champions for Bootle area.

2 public advisors; Tim & Lucy

**4. Please summarize the results of your assessment under the section headings. For each stage, highlight the changes to your activity as a result of the assessment. If you did not make any changes, please give your reasons why.**

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| **What are the health inequalities that influence(d) or create(d) the problem being addressed by your project?** | Bootle ward profile:<br>There are a total of 31,684 residential properties in Bootle, which represents 27% of the borough housing stock. There has been a 1% reduction in the number of households compared to 2001. This is in contrast to the 1% increase seen across Sefton as a whole. Bootle has a rate of 24 vacant and void properties per 1,000 properties, higher than the rate in Sefton (20).<br><br>Of the 31,684 residential properties in Bootle; 35% are resided in by only one person, a rate of 346 per 1,000 properties. This is higher than the Sefton, North West and England rates (32%, 31% and 30% respectively).<br><br>There are 35 Lower Super Output Area's across Sefton that fall into the most deprived 10% of areas nationally, 30 of which fall into the Bootle township area. This equates to over half of the 53 LSOA's that make up the township. There are three LSOAs within Bootle Township that fall within the worst 1% nationally, all of which are in the Linacre Ward area, and 21 that are in the worst 5%. This means 56.2% (40,725) of Bootle township residents live in areas in the most Deprived 10% nationally, with 4% (3,778) of residents living in areas that are in the most deprived 1%.<br><br>Latest available information (May 2014) shows the number of working age people in Bootle township claiming benefits is 12,675 or 27%. The percentage of Bootle township claimants is not only higher than the Sefton rate of 17%, but considerably higher than the regional rate of 16% and over double the national rate of 13%<br><br>Between January and December 2014, Bootle township accounted for 38% (5,572 of 14,507) of Sefton's crimes reported to Merseyside Police. Equating to 76 crimes per 1,000 residents, higher than the rate in Sefton as a whole (53 per 1,000 residents). Between January and December 2014, Bootle township accounted for 41% (3,766 of 9,209) of Sefton's Anti-Social Behaviour (ASB) reported to Merseyside Police. This equates to 52 incidents per 1,000 residents, higher than the Sefton rate of 34 per 1,000 residents.<br><br>Between January to December 2014, Bootle accounted for 49% (4,910 of 9,990) of Sefton's Environmental issues reported to Sefton council. This equates to 67 issues per 1,000 residents which is considerably higher than the rate across Sefton as a whole (37 per 1,000 residents).<br><br>In total 35% (20,176) of residents within the ward stated that they did not have any form of qualification. This equates to 345 per 1000 residents, higher than the Sefton rate of 251 per 1000 residents. According to the Census 2011, general health within the Bootle township is on par with the rest of the borough, with 75% (54,546) of residents describing their general health as either very good or good, lower than the percentage seen across Sefton as a whole (77%). 25% (18,147) of the township's residents state that their daily activities are limited in some way; higher than the Sefton rate (22%). Twenty four of the 52 LSOAs in Bootle are within the top 20% areas with residents deemed to have bad or very bad health, with seventeen being in the top 20% for long-term health problems. 12% (7,142) of the townships residents are providing unpaid care, slightly lower than the figure for Sefton (13%). |

| | Between 2008/09 and 2012/13 there have been 12,026 hospital stays for alcohol related harm in the Bootle township. In order to allow comparison with other areas this has been turned into a standardised admissions ratio (SAR). Bootle has an SAR of 159, considerably higher than that of Sefton (119) and England (100). |
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| **How will your proposed work tackle the socio-economic causes of the inequalities in health you have identified as relevant?** | Community Connectors Project:<br>Service Client Profile: Age 18+ who are at risk or feeling lonely and isolated, with low level mental health needs, and not meeting eligibility criteria of Adult Social Care.<br>Service delivery area: Southport, Maghull and Bootle.<br>Service delivery time scale: 14 week supported intervention.<br>What happens within Adult Social Care? Contacts to ASC will be triaged at first point of access; triggers will identify the appropriate pathway for callers who would not be offered social care assessments. These clients are collected on a weekly basis and referred to Community Connectors.<br><br>What happens to the client? Upon referral, a Community Connector will arrange to visit client in their own home. They will carry out the Warwick Edinburgh Mental Wellbeing Scale and De Jong Geirveld Loneliness Scale with the client, as well as developing a rapport around their likes and dislikes, their ability and confidence to travel on public transport, and gauging what they require assistance with. They are paired up with a volunteer Community Champion who makes contact with them to help them achieve their weekly tasks or a goal of attending a local group. Both the Community Connector and Champion keep in contact with the client throughout their 14 weeks and the Connector will meet with them around week 7 and week 14 to conduct the 2 questionnaires again. Upon completion of the project, the client is given the option to become a Community Champion. They will also help people to build individual resilience by facilitating opportunities to connect, be active, take notice, and keep learning and give. People's self-esteem will be increased by encouraging them to be contributors through sharing their skills, knowledge, experience and interests.<br><br>Our aim for the client: The intervention of the Community Connector and Community Champion will provide opportunities to help the client increase their social circle by travelling with them to different local groups and organisations, and introducing them to people there so they can make new friendships. It will also help them to feel more confident in completing weekly tasks such as going to a supermarket, or simple DIY tasks such as changing a lightbulb, so they can do these tasks themselves or have family and friends to turn to for help, before small tasks become a big issue which are left un-tackled and emergency services or Adult Social Care become involved.<br>Referrals received from: Sefton Adult Social Care, Self/family referral, GP/Health Professional, local group or organisation. Our flyers and posters are visible in Sefton Council Contact Centre, GP surgeries, local supermarkets, places of worship, leisure centres, libraries, and our service is promoted on social media (Facebook and Twitter). We believe that Social Workers, Occupational Therapists and other professionals carry our information with them to promote to their patients and clients. According to the 2011 Census 96% of Bootle residents deem themselves to be White British, therefore all of our promotional resources are only available in English language.<br>For the purpose of the CLAHRC evaluation project we will be focussing on the Bootle area. Sefton is a very diverse area, with high levels of deprivation in the south of the borough. Areas such as Bootle generally have higher health inequalities than the rest of the borough, and some higher than national average. The further north you travel in Sefton, the more affluent the areas are. For example people living in Southport (north Sefton) are likely to live 11 years longer than those living in Bootle.<br>The socio-economic circumstances in which our clients live and work could limit their ability to access our service, and adhere to it such as: |

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| | <ul><li>Our paid staff work Monday to Friday. Some clients may require assistance out of normal working hours. As a result our volunteer Community Champions are encouraged to have some availability during evening and weekends. For example we have a male client, who lives alone and is lonely and socially isolated who wants someone to watch the football on TV with him during the weekend.</li><li>Our Bootle Community Connector is male and has had many female clients. When pairing up clients with Community Champions we do ask if they would prefer a male or female volunteer, and when Community Champions are recruited we also ask them if there are any specific groups of people they prefer not to work with. This helps us to make a successful match as soon as possible.  If we identify the client stops engaging with us we can ask if they would prefer a female Community Connector, and we can bring in Hannah from Southport or Gill from Maghull.</li></ul><br>As a result we can look into the following partnerships to help limit these barriers:<ul><li>Local groups which operate during evenings and weekends</li></ul> |
| **How will you make sure that your evaluation and monitoring shows the effect of your activity on health inequalities and their causes?** | As part of our monitoring and evaluation, I will be producing monthly, quarterly and annual reports which collect quantitative data from the following:<br>Sefton CVS data collection:<ul><li>Number of referrals</li><li>Where client was referred from</li><li>Number of referrals per area (Southport, Maghull or Bootle)</li><li>Specified gender, ethnicity, working status, age group.</li><li>Number of initial visits conducted</li><li>Difference in mental well being and loneliness scores from questionnaires</li><li>Number of people introduced/accessing different groups, organisations or services as a result of their referral to our project</li><li>Number of clients referred back to Adult Social Care as case too complex for us</li><li>Number of clients not suitable / not wanting to engage</li><li>Number of clients on hold (i.e moving house, in hospital etc)</li><li>Number of Community Champions recruited</li><li>Number of Community Champions attending training day</li><li>Number of Community Champions obtaining DBS</li><li>Number of completed clients becoming Community Champions.</li><li>Qualitative case studies</li></ul>Sefton Adult Social Care triage team:<ul><li>Number of calls on their log per week</li></ul>Sefton Council Contact Centre:<ul><li>Total number of calls relative to Adult Social Care per week</li><li>Number of calls signposted to other services</li><li>Number of repeat contact calls</li><li>Number of calls signposted using LAS (Liquid Logic Adult Social)</li><li>Number of new cases from calls</li></ul> |
| **What wider effect might your activity have on health inequalities and their causes and how can this be delivered?** | Clients who have a positive experience of engaging with a Community Champion may encourage them to become a Community Champion themselves, and help future clients in need. In doing so, they will be given the opportunity to attend Champions training days with us where we provide MECC (Making Every Contact Count) training and Safeguarding Vulnerable Adults training. In turn they become more knowledgeable and informed. Community Champions are paid for any expenses they incur as a direct result of helping out a client, or attending training with us. We are tracking the number of volunteering hours they work during their time with us and |

providing we have the funding we will look at providing awards for those who have worked the most hours.

I will be ensuring that the Community Connectors hold bi-monthly forums with their volunteer Community Champions in each of their local areas, in order for us to collect data, monitor our findings and change our service delivery to meet the changing needs of our clients. The Community Connector can discuss new clients they have who require help from a volunteer Community Champion, and put the onus on the Champions to choose their next client to work with. I have decided to introduce the Warwick Edinburgh Mental Wellbeing Scale at these bi monthly forums to monitor the Community Champions wellbeing and see if this improves during their time with us. This may or may not be as a direct result of engaging with our project, so would be difficult to justify any changes.

Given that Community Connectors is an 18 months fixed term project (ending December 2018), and the CLAHRC evaluation should complete in Summer 2018, I would like to get some case studies together from Volunteer Community Champions on how they have found the project overall, how it has helped them, the clients they worked with; their overall experience.

There may be times during home visits, general engagement phone calls, volunteer forums, or when developing our partnership with Adult Social Care when we identify unintended effects of our service; which could be positive or negative. We will aim to feedback these to the relevant people, so they can be rectified if possible, or promoted and used for further funding applications.

An example of a negative unintended effect:
- We first started attending Adult Social Care triage team on a weekly basis in June 2017. Once the team identified a client on their call log who didn't meet the criteria for a Social Worker assessment they were referred to Community Connectors. We completed a referral form and the triage team would update their database to say this client had been assigned to Sefton CVS Community Connectors team, which automatically removed the client from the call log. Initially this was a positive result as we could see an immediate reduction in the number of people on the call log/waiting list.
  However, there were a few cases upon completing a home visit the client wanted us to help them with loneliness and social isolation, but still needed a Social Worker Assessment and it was clear from meeting the client that they definitely did meet the criteria for Social Care. Because these clients had been removed from the call log, they had also been removed from the waiting list which meant they had to be added again, but went to the bottom of the waiting list as opposed to being contacted at their initial place in the queue. We worked with Adult Social Care staff to rectify this so no clients were removed from the queue even when they were allocated to Sefton CVS for the Community Connectors input, until the Connector had completed an initial home visit to make this decision.

An example of a positive unintended effect:
- We currently have 3 members of a local group in Maghull called Yarnigans who have registered as Community Champions and have attended our first training day which took place in Bootle. As a result of attending the training day they set up another 2 Yarnigans groups in Bootle upon hearing there was a demand for a knitting group.